Supreme Court, U.S.
FILED
AUG 3 - 2006
OFFICE OF THE CLERK

(18)

No. 05-1382

IN THE

Supreme Court of the United States

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL.,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

AMICUS BRIEF OF THE AMERICAN CENTER FOR LAW AND JUSTICE IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

In light of the centrality of maternal "health" arguments in this case, should this Court keep in mind that the assumption that abortion is safer than childbirth is unsupported and apparently incorrect?

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INTEREST OF AMICUS[1]

The American Center for Law and Justice ("ACLJ") is a public interest law firm dedicated, *inter alia*, to the defense of the sanctity of human life. ACLJ attorneys have appeared frequently before this Court as counsel for parties or for amici.

The ACLJ (joined by others) filed an amicus brief in the pending case of *Gonzales v. Carhart*, U.S. No. 05-380, defending the constitutionality of the federal Partial Birth Abortion Ban Act. The present brief is not duplicative of that brief, but rather addresses a different but important subject, namely, the misconception that abortion has been proven to be safer than childbirth.

SUMMARY OF ARGUMENT

The assertion that abortion is safer than childbirth has always been based on a combination of incomplete information and disparate definitions. But during the last ten years, major record-based studies linking deaths to prior pregnancy outcomes have demonstrated that abortion is actually associated with a higher risk of death for women than childbirth. The risk of suicide following abortion, for example, is approximately six times higher. Whereas *Roe v. Wade* made the comparative risks of abortion versus childbirth a critical issue in abortion law, this Court should not ignore this important new evidence.

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[1] The parties in this case have consented to the filing of this brief. Copies of the consent letters are being filed herewith. No counsel for any party authored this brief in whole or in part. No person or entity aside from the ACLJ, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

ARGUMENT

An understanding about the relative safety of abortion versus childbirth has been an important consideration in this Court's abortion jurisprudence. Most notably, the trimester framework which was established in *Roe v. Wade*, 410 U.S. 113 (1973), and which governed abortion cases until *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), hinged in part on the premise that "until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." *Roe*, 410 U.S. at 163. *See also id.* at 149 & n.44 (asserting that "[m]ortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low or lower than the rates for normal childbirth") (citing, *inter alia*, abortion mortality figures from U.S. Department of Health, Education, and Welfare (HEW)).

Abortion providers and their advocates, not surprisingly, have regularly repeated the mantra that abortion (at least early abortion) is safer than childbirth. *See, e.g.*, www.prochoice.org/about_abortion/facts/safety_surgical_abortion.html (website of National Abortion Federation) ("Complications from having a first trimester abortion are considerably less frequent and less serious than those associated with birth"); www.guttmacher.org/pubs/fb_induced_abortion.html (website of Alan Guttmacher Institute, the research arm of Planned Parenthood) ("the risk of death associated with childbirth is about 12 times as high as that associated with abortion"); www.aclu.org/reproductiverights/youth/16388res20010401.html (website of ACLU) ("abortion is safer than childbirth"); www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/abortion/fact-abortion-medical-social-benefits.xml (website of Planned Parenthood Federation of America) (abortion is "eleven times safer than carrying a pregnancy to term"); www.abortionaccess.org/viewpages.php?id=170 (website of Abortion Access Project) (abortion "11 times safer than childbirth"); www.womensmedcenter.com/abortioncare/default.asp (website of Women's Med Center, an abortion

provider) ("Abortion is 5 to 10 times safer than childbirth"); www.safestabortion.com/surgical.html (website of New York OB/GYN, an abortion provider) ("statistically, it is 9 times more dangerous to go through childbirth than to have a surgical abortion").

Respondents Planned Parenthood *et al.* make the same assertion in this case. *See* Decl. of Maureen G. Paul, M.D. at 6, ¶ 18 ("at the gestational ages that most abortions are performed, abortion is many times safer than continuing pregnancy through childbirth") (offered by respondents in support of their motion for TRO and for preliminary injunction).

While the *Roe* Court treated the relative safety of (early) abortion over childbirth as "now-established medical fact," 410 U.S. at 163, this "fact" is no such thing. First of all, the unthinking comparison of maternal mortality and abortion mortality statistics is **not** probative; rather, it is mixing apples and oranges. Secondly, the medical literature strongly, arguably overwhelmingly, suggests that abortion is **poor** health care for women, in particular relative to the alternative of childbirth.

I. ABORTION MORTALITY STATISTICS AND MATERNAL MORTALITY STATISTICS ARE *NOT* COMPARABLE AND THUS DO *NOT* PROVE THAT ABORTION IS SAFER.

Common sense would suggest that the deliberate surgical or chemical interruption of a normal, natural process like gestation would be less healthy than allowing that process to continue. Pregnancy, after all, is not a disease. Nevertheless, national mortality statistics appear, at least at first glance, to show that abortion is safer than childbirth. Thus, for example, the Kaiser Family Foundation, citing statistics from the United States government, quotes an abortion mortality rate of "0.6 per 100,000 abortions," and, "[f]or comparison," a risk of maternal death from childbirth of "6.7 per 100,000 deliveries." *See* Fact Sheet: Abortion in the U.S. (Oct. 2002) (available at

www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14090). A mechanical comparison of these two figures would give the false impression that childbirth is indeed many times more dangerous than abortion.

The problems with such a comparison, however, are many.

A. Inherently Different Measures

First, the measures are intrinsically noncomparable. As the director of the Centers for Disease Control recently explained, the maternal mortality and abortion mortality "measures are conceptually different and are used by CDC for different health purposes." Letter of July 20, 2004 from Julie Louise Gerberding, M.D., M.P.H., Director, Centers for Disease Control, to Walter M. Weber, p. 1. (This letter, as well as the letter that prompted it, are included as addenda to this brief.) In other words, the measures are apples and oranges that cannot be compared one-to-one.

Maternal mortality is determined by dividing maternal deaths by **live births**, not by **pregnancies**. *See, e.g.,* www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm (Pregnancy-Related Mortality Surveillance -- United States, 1991-1999 (Centers for Disease Control Feb. 21, 2003)) (hereinafter "Pregnancy Mortality") ("Pregnancy-related mortality ratios were calculated by using the number of deaths . . . (numerator) and live-birth data (denominator) . . ."). This will necessarily tend to inflate the mortality rate, as many pregnancies end in miscarriage or stillbirth. For example, a woman who dies from an ectopic pregnancy will count as a maternal death but will not count for purposes of the live birth total.[2] And the far greater number of

[2] Thus, even though many women survive ectopic pregnancies, the supposed maternal mortality rate for all ectopic pregnancies will be infinitely high. There will be **some** maternal deaths in the numerator but **no** live births in the denominator, yielding an infinitely large fraction. Obviously, this is erroneous. Moreover, this error will distort the overall maternal mortality

(continued...)

women who survive an ectopic pregnancy will not be counted at all. Women who suffer miscarriages and die from associated complications will likewise be counted as maternal deaths, but neither they nor the vastly larger number of women who survive miscarriages will count toward the baseline, which requires live birth. The abortion mortality rate, by contrast, counts all abortion procedures, thus maintaining a fuller base (denominator) for rate computation. *See* www.cdc.gov/mmwr/preview/mmwrhtml/ss5212a1.htm (Abortion Surveillance -- United States 2000 (CDC Nov. 28, 2003)) (hereinafter, "Abortion Surveillance 2000") ("National case-fatality rates were calculated as the number of known legal induced abortion-related deaths per 100,000 reported legal induced abortions").

The measures are also conceptually distinct because the overall maternal mortality figures do not account for the stage of gestation. Whereas 55% of maternal deaths occur in the first 42 days (six weeks) of pregnancy, *see* Pregnancy Mortality, *supra* p. 4 (last paragraph of "results" section), the overall maternal mortality rate will misleadingly suggest more than twice the actual, prospective risk of a continued pregnancy, even at that early stage (42 days) of gestation. Obviously, for example, a woman entering her second trimester faces zero risk of a first-trimester death from ectopic pregnancy -- the leading cause of first-trimester maternal deaths, *see supra* note 2 -- yet the undifferentiated maternal mortality rate incorporates those first-trimester deaths. Again, a straight comparison of abortion mortality versus childbirth mortality rates will be erroneous. An abortion cannot eliminate a risk that has already passed. A true comparison would have to assess only the **prospective** risk of continuing the pregnancy, not the risk **throughout** pregnancy.

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[2] (...continued)
rate by adding to the numerator (deaths) while not adding to the baseline denominator (live births). Notably, ectopic pregnancies are the leading cause of deaths in the first trimester. *See, e.g.*, www.cdc.gov/mmwr/preview/mmwrhtml/00035709.htm (Current Trends Ectopic Pregnancy -- United States, 1990-92 (CDC Jan. 27, 1995)). Hence, this is no trivial distortion.

B. Abortion Mortality Undercounting

Second, a fair statistical comparison of the risks of death from abortion versus continued pregnancy is impossible if the underlying data is itself inaccurate or incomplete. The failure to report abortion-related deaths is apparently all too common. David C. Reardon, Thomas W. Strahan, John M. Thorp, Jr. & Martha W. Shuping, *Deaths Associated with Abortion Compared with Childbirth -- A Review of New and Old Data and the Medical and Legal Implications*, 20 J. Contemp. Health Law & Pol'y 279, 286-91 (2004) (hereinafter "Reardon, *Deaths Associated with Abortion*"). This undercounting will in turn yield an underestimate of the abortion mortality rate.

Such underreporting is in some ways perfectly understandable. The woman may have concealed the abortion from her loved ones. The physician or coroner may, to spare the family further grief or stigma (or out of ignorance of the underlying abortion), simply report death as being due to "sepsis" or "hemorrhage" or "embolism" rather than noting an abortion connection. By contrast, there is little incentive to conceal deaths due to childbirth or complications of pregnancy, and such deaths are thus more likely to be counted. And to the extent an **abortion-related** death is reported as a **maternal** death, this will further skew the statistics toward a false view of abortion being relatively safer.

Also contributing to the undercounting of abortion is the unreliability of death certificates or official reports as sources of information regarding associated abortions. *See id.* at 289-90 (noting that official coding standards impede the reporting of abortion deaths). *See also* Mika Gissler, *et al.*, *Methods for identifying pregnancy-related deaths: population-based data from Finland 1987-2000*, 18 Paediatric & Perinatal Epidemiology 448, 451 (2004) (text and Table 2) (94% of abortion-associated deaths were not identified from death certificates or cause-of-death registries alone).

C. Disregard of Non-Immediate Sequelae

Third, abortion mortality rates reflect death ensuing from the procedure itself. *See* Abortion Surveillance 2000, *supra* p. 5 (last paragraph of "Methods" section) ("abortion-related death" defined as death from "direct complication," "indirect complication," or "aggravation of a preexisting condition"). They do **not** reflect longer term adverse consequences. Recent studies indicate, however, that abortion is associated with an increased rate of both short-term and long-term maternal death. *Infra* § II. A fair comparison of abortion with continued childbearing, like a fair comparison of smoking with nonsmoking, would have to take into account not just immediate consequences, but also all other statistically significant increased death risks. Whereas the mortality rates invoked to prove the supposed relative safety of abortion fail to include statistically significant increases in overall mortality after abortion, reliance upon such limited data is dangerously incomplete.

II. PUBLISHED LITERATURE INDICATES THAT, IF ANYTHING, ABORTION IS *MORE* DANGEROUS THAN CONTINUED PREGNANCY.

Published research strongly indicates that abortion, rather than being safer than childbirth, is in fact more dangerous.

In Finland, for example, researchers drew upon national health care data to examine the pregnancy history of **all** women of childbearing age who died for any reason, within one year of childbirth, abortion, or miscarriage, between the years of 1987 and 1994 (a total of nearly 10,000 women). The study found that, adjusting for age, women who had abortions were 3.5 times more likely to die within a year than women who carry to term. Mika Gissler, *et al.*, *Pregnancy-associated deaths in Finland 1987-1994 -- definition problems and benefits of record linkage*, 76 Acta Obstetrica et Gynecologica Scandinavica 651 (1997).

A subsequent study based upon Medicaid records in California likewise found significantly higher mortality rates after abortion. The study linked abortion and childbirth records in 1989 with death certificates for the years 1989-97. This study found that, adjusting for age, women were 62% more likely to die from any cause than women who gave birth. David C. Reardon, *et al.*, *Deaths associated with pregnancy outcome: A record linkage study of low income women*, 95 So. Med. J. 834 (2002).

The Gissler and Reardon studies both showed, *inter alia*, a heightened risk of suicide after abortion.[3] A recent British study found the same thing. Christopher L. Morgan, *et al.*, *Mental health may deteriorate as a direct effect of induced abortion*, 314 British Med. J. 902 (Mar. 22, 1997) (letters section) (found suicide attempts more than four times as frequent after abortion than after childbirth). All three studies are consistent with the many studies documenting adverse emotional consequences after abortion. *See* David C. Reardon, *Abortion Decisions and the Duty to Screen: Clinical, Ethical and Legal Implications of Predictive Risk Factors of Post-Abortion Maladjustment*, 20 J. Contemp. Health L. & Pol'y 33, 39 n.14 (2003) (citing nearly three dozen sources).

A related consequence of abortion is the elevated risk of substance abuse. *See, e.g.*, David C. Reardon & Phillip G. Ney, *Abortion and Subsequent Substance Abuse*, 26 Am. J. Drug & Alcohol Abuse 61 (2000); David C. Reardon, *et al.*, *Substance use associated with unintended pregnancy outcomes in the National Longitudinal Survey of Youth*, 26 Am. J. Drug & Alcohol Abuse 369 (2004); Priscilla K. Coleman, *et al.*, *Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy*, 10 British J. Health Psychol. 255 (2005).

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[3] *See also* Mika Gissler, *et al.*, *Suicides after pregnancy in Finland: 1987-94: register linkage study*, 313 British Med. J. 1431 (1996) (suicide rate after induced abortion was six times higher than suicide rate after childbirth).

Of course, abortion can also cause physical harm. This can result directly from the procedure itself (e.g., perforation of the uterus, laceration of the cervix), from the deprivation of the health benefits of continuing pregnancy (e.g., eliminating the protective effect of a full-term pregnancy against breast cancer),[4] or by masking other dangerous symptoms (e.g., a woman with an infection or an ectopic pregnancy may believe her symptoms are merely normal after-effects of abortion, leading her to delay seeking medical help).[5] *See generally* "A List of Major Physical Sequelae Related to Abortion" (Elliot Institute) (available at www.afterabortion.org) (listing sequelae and referencing sources); Reardon, *Deaths Associated with Abortion*, *supra* p. 6, at 311-17 (same).

In sum, there is ample reason to believe that abortion is **detrimental** to maternal health and, if anything, **more likely** to lead to death or other adverse consequences than is continuing the pregnancy.

* * *

This Court should take with a very large grain of salt any assertion that abortion is healthy for women, much less some sort of panacea. There is good reason to believe precisely the contrary.

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[4] *See* Justin D. Heminger, *Big Abortion: What the Antiabortion Movement Can Learn from Big Tobacco*, 54 Cath. U.L. Rev. 1273, 1288-89 & nn.119 & 121 (2005) (citing sources).

[5] *Cf.* Reardon, *Deaths Associated with Abortion*, *supra* p. 6, at 284 & nn.26-27 (CDC does not count as abortion death a death from ectopic pregnancy that ruptures after the woman had an abortion, even though "the deaths are at least partially due to the failure of the abortion provider to verify the site of the pregnancy and the completion of the abortion").

CONCLUSION

This Court should reverse the judgment of the Ninth Circuit.

Respectfully submitted,

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August 3, 2006

ADDENDA

ACLJ
American Center
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April 30, 2004

Tommy G. Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Abortion statistics and maternal health

Dear Secretary Thompson:

In the challenges to the federal partial birth abortion statute, as on many other occasions, the proponents of legalized abortion make the claim that abortion is safer for women than childbirth. There is very good reason to believe that this claim is false. However, a fair scientific examination of this claim is hindered by the way the Centers for Disease Control (CDC) maintains its relative maternal mortality statistics.

I am writing to urge your office to direct a reassessment of the pertinent statistical measures. In short, the HHS should see to it that the American public -- and in particular, women contemplating the choice between abortion and continuing

pregnancy -- have a genuine basis for an honest and meaningful comparison of the relative risks. If, in the alternative, the CDC is unable to provide a basis for a true comparison, it should so state.

The CDC has in the past reported maternal mortality as the "[n]umber of maternal deaths per 100,000 live births." See, e.g., www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054602.htm (Fig. 1, footnote *) (Maternal Mortality -- United States, 1982-1996). Abortion mortality, by contrast, is reported as the number of "[l]egal induced abortion-related deaths per 100,000 reported legal induced abortions." See, e.g., www.cdc.gov/mmwr/preview/mmwrhtml/ss5212a1.htm (Table 19, footnote *) (Abortion Surveillance -- United States, 2000).

Here are some of the concerns with these statistics:

1. Denominator too small for maternal mortality rate

Maternal mortality should reflect deaths per pregnancy, not deaths per live birth. Stillbirths and miscarriages are fairly common occurrences.[1] To count maternal deaths associated with miscarriages, for example, while not counting the pregnancies, improperly inflates the maternal mortality rate.[2]

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[1] See, e.g., www.cdc.gov/nchs/releases/00facts/trends.htm ("6 million-plus pregnancies in 1996 in the U.S. resulted in 3.9 million births, 1.3 million induced abortions and almost a million fetal deaths," i.e., "16 percent [ended] in a miscarriage or stillbirth").

[2] Of course, live births should be counted only once for each labor, regardless of whether the woman bears at one time a single child, twins, triplets, or a greater number.

2. No maternal mortality rate adjustment for gestational stage

The relative risk of aborting versus continuing a pregnancy should reflect the prospective risks only, and not risks associated with stages of pregnancy already passed. For example, ectopic pregnancies cause a significant percentage of maternal deaths, and indeed are the leading cause of deaths in the first trimester. See, e.g., www.cdc.gov/mmwr/preview/mmwrhtml/00035709.htm (Current Trends: Ectopic Pregnancy -- United States, 1990-92). Obviously, a woman entering her second trimester faces zero risk of a first-trimester death from ectopic pregnancy, yet the undifferentiated CDC maternal mortality rate incorporates those first-trimester deaths. An abortion cannot eliminate risks that have already passed; only prospective risks should enter into the comparison.

3. Underreporting of abortion-related deaths

A true statistical comparison of the risks of death from abortion versus continued pregnancy is impossible if the statistics are inaccurate. Thus, the apparently common failure to report abortion-related deaths see www.afterabortion.org/PAR/V8/n2/abortiondeaths.html ("The Cover-Up: Why U.S. Abortion Mortality Statistics Are Meaningless"), underestimates the abortion mortality rate. The same problem would apply to any underreporting of other maternal deaths. (And, of course, abortion-related deaths must be excluded from the maternal mortality rate if any comparison is to be made. Counting abortion deaths as maternal deaths as well -- or instead -- stacks the deck against childbearing and in favor of abortion.)

4. Disregard of non-immediate deaths

Recent studies indicate that abortion is associated with an increased rate of short-term and long-term maternal death. See www.afterabortion.org/physica.html ("A list of Major Physical Sequelae Related to Abortion"). A fair comparison of abortion with continued childbearing, like a fair comparison of smoking with nonsmoking, would take into account all such statistically significant increased death risks.

* * *

Women choose or decline abortions for many different reasons, and the decision for many may represent a complex balance of multiple considerations. It is a grave disservice to withhold from women the information needed for a genuine comparison between abortion mortality and the risk of mortality from continuing the pregnancy. Such information may be decisive for many women. Moreover, abortion businesses, which have profit motives for women to choose abortion, cannot be relied upon to present the full picture. Indeed, such businesses may be using statistics -- despite the flaws described above -- to help sell abortion to trusting lay women. Cf. www.abortion.com/questions.html (claiming that "statistically, childbirth is far more dangerous than abortion").

I strongly urge you to direct the CDC to make all necessary adjustments to its preparation and presentation of statistical data to allow for an honest, unbiased comparison of the relative risks of abortion and continuing pregnancy.

Very truly yours,

/s/
Walter M. Weber
Senior Litigation Counsel

WMW:fd

cc: Timothy Goeglein
Terrell Halaska

DEPARTMENT OF HEALTH
& HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

JUL 20 2004

Mr. Walter M. Weber
Senior Litigation Counsel
American Center for Law & Justice
201 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Weber:

We appreciate your interest in the Centers for Disease Control and Prevention's (CDC) efforts to collect and publish maternal mortality statistics (including those related to abortion). CDC makes every effort to identify all such deaths and to present maternal mortality statistics using established scientific methods.

The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions. These measures are conceptually different and are used by CDC for different public health purposes.

CDC calculates the maternal mortality rate per 100,000 live births for the following reasons:

1. To maintain comparability in long term trends for the United States. Estimates of the number of pregnancies (including live births, miscarriages or stillbirths, and induced abortions) in the United States have been published only since the 1970s.
2. The live birth component of the pregnancy estimates is highly reliable. Virtually all births are counted in every year. Estimates of all abortions are based on CDC's abortion surveillance system, which relies on state abortion reporting systems. Estimates of stillbirths, ectopic pregnancies, and miscarriages are based on survey data and are subject to significant sampling error, particularly for smaller population subgroups. Estimates of stillbirths and miscarriages are based on pregnancy history data from the National Survey of Family Growth (NSFG). The NSFG is conducted periodically, every 5 to 7 years. The data are subject to sampling error, particularly for smaller population subgroups. For information on the estimation methodology, see www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.
3. To maintain international comparability. Many other countries cannot adequately estimate the number of pregnancies, especially those in which abortion is illegal. Information on miscarriage and stillbirth also varies considerably in completeness. In the interest of international comparability, the World Health Organization has specified that the number of live

births should be used for the denominator of the maternal mortality rate.

Adjusting the maternal mortality rate for gestational stage is not statistically feasible, because this requires data that are not currently completely available. The Pregnancy Mortality Surveillance System (PMSS) relies primarily on death certificates which do not typically provide this information. Gestational age may be available for some maternal deaths in cases where linkage with other records (e.g., birth certificates, fetal death reports) is possible. Information on gestational age for induced abortions is available in about 42 states or jurisdictions.

CDC recognizes that despite efforts to count all maternal deaths (including those abortion-related) in the United States, some remain uncounted. The death itself is reported but accurate information on the cause may not be provided. CDC estimates that maternal deaths in general are underreported by 30 to 15 0 percent (see www.cdc.gov/mmwr/preview/mmwrhtml/ss52 02e1.htm). The nature of the surveillance systems make it difficult to obtain complete data. The PMSS compiles data from 50 states, the District of Columbia, and New York City. Abortion surveillance involves data from 47 states, District of Columbia, and New York City. These systems are voluntary (CDC does not provide remuneration for data) and rely primarily on death certificate data which may or may not provide information that indicates the death was maternal or abortion-related. In the case of deaths associated with induced abortion, CDC also uses searches of computerized print media databases (Lexis-Nexis) to identify additional cases.

At CDC we are very committed to improving data collection systems and providing the most accurate and reliable data on all aspects of maternal and infant health. I hope this information is helpful.

Sincerely,

/s/
Julie Louise Gerberding, M.D., M.P.H.
Director